Substitute per letter dated 6/12/02

4. The request for rate reconsideration must be submitted in writing to the Division, must specifically and clearly identify the reason for the request, must include sufficient documentation evidencing that the costs were actually incurred, must be in detail sufficient for the division to determine whether or not the costs were or were not included in the rate, and must include the amount requested;

5. The Division will make a recommendation to the director of the Department of Social Services within sixty (60) days following the receipt of all documentation required or necessary, or both, to evaluate the request. The director's or his / her designee's final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the Division's recommendation; and

6. The director's or his / her designee's final determination on the Division's recommendation shall become effective on the first day of the month in which the request was made providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective on the first day of the following month.

(13) Rate Adjustments.

(A) Unless specifically provided elsewhere in these rules, the division may increase or decrease the per-diem rate both prospectively and retrospectively only under the following conditions:

1. Pursuant to a court decision; or

2. Pursuant to an Administrative Hearing Commission decision or order.

APPENDIX C

Year	Asset Value
1994	S 32,330
1995	S 32,723
1996	S 32,921
1997	S 33,355
1998	S 33,829
1999	S 34,205
2000	S 34,797

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 7

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
CFR 42

7. FEDERAL BUDGET IMPACT:
a. FFY 02 $0
b. FFY 03 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4-19D pg.73, 73a, 75, 75a, 76, 77, 90, 90a, 105, 106, 107, 107a, 107b, 107c, 107d, 107e, 107f, 107g, 107h, 107i, 107j, 110, 110a, 120a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4-19D Pages
73, 73a, 75, 75a, 76, 77, 90, 90a, 105, 106, 107, 107a, 107b, 107c, 107d, 107e, 107f, 107g, 107h, 107i, 107j, 110, 110a, 120a

10. SUBJECT OF AMENDMENT: Provides for rate changes for additional and replacemnt beds for Pediatric nursing facilities. Also the capital rate is based on the FRV methodinstead of the Dodge calculator method. Splits the level-of-care ceiling between capital and all other.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT Cel
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Christine Lackers for

13. TYPED NAME:
Dana Katherine Martin

14. TITLE:
Director

15. DATE SUBMITTED:
3/28/02

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
03/29/02

18. DATE APPROVED:
JUN 18 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01/01/02

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Blaze for

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid & State Operations

23. REMARKS:
cc:
Martin
Vadner
Waite
CO
DSG/DIATA

SPA CONTROL

Date Submitted: 03/28/02
Date Received: 03/29/02

FORM HCFA-179 (07-92)

Instructions on Back

per-diem rate. No payments may be collected or retained in addition to the Medicaid per-diem rate for covered services. Where third-party payment is involved, Medicaid will be the payer of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Services. A provider participating under this rule shall not be eligible for participation under any other Missouri Medicaid plan for the provision of nursing care services.

(E) The Medicaid per-diem rate shall be the lower of:

1. The average private pay rate;

2. The Medicare (Title XVIII) per-diem rate, if applicable;

3. The per-diem rate as determined in accordance with section (11); or

4. The level-of-care ceiling. Effective July 1, 1999, the level-of-care ceiling shall be the weighted average Medicaid allowable cost for all participating pediatric nursing facilities as determined from their 1992 cost reports adjusted by the same percentages stated in 13 CSR 70-10.015 for 1992 cost reports and any negotiated trend factors effective through July 1, 1999. The weighted average rate is three hundred twenty-one dollars and forty-five cents ($321.45) as of July 1, 1999. Effective January 1, 2002, the level-of-care ceiling will be split for that portion related to the patient care and general and administrative per diems and for that portion related to the capital per diem. The level-of-care ceiling for

patient care and general and administrative per diems effective January 1, 2002, is three hundred eighteen dollars and sixty-three cents ($318.63) and the capital per diem level-of-care ceiling is seven dollars and forty-four cents ($7.44). For any facility which the capital per diem rate is calculated based on subpart (11)(A)3.B., the fair rental value system, the capital per diem level of care ceiling will not be applied. The level-of-care ceiling shall be adjusted by the negotiated trend factor given in subsection (13)(A) or any global adjustment in section (13) of 13 CSR 70-10.015.

(J) A facility's allowable costs shall be apportioned between Medicaid recipients and other patients so that the share borne by the Medicaid program is based upon services actually provided to Medicaid recipients. A facility's allowable costs allocated to the Medicaid program in no case may include costs incurred in providing services for persons who are not Medicaid eligible.

(K) A facility that also is certified for participation in the Title XVIII (Medicare) program shall meet the requirements of Title XVIII of the Social Security Act. Any facility which is terminated from participation in the Medicare program also shall be terminated from participation in the state's Medicaid program.

(L) No restrictions or limitations shall be placed on a recipient's right to select providers of his / her own choice.

(4) Definitions.

(A) Allowable cost. Those costs which are allowable for allocation to the Medicaid program based upon the principles established in this regulation. The allowability of costs not addressed specifically in this regulation shall be determined by the Division of Medical Services. This determination may be based upon criteria such as the Medicare Provider Reimbursement Manual (HIM-15) and section (7) of this regulation.

(B) Asset value. The asset value is the per bed cost of construction used in calculating a facility's capital per diem utilizing the fair rental value system as set forth in subpart (11)(A)3.B.. The cost of

construction is based on the RS Means Building Construction Cost Data to determine specific cost information for current, historical and projected costs. The initial asset value was based on 1994 costs utilizing the median total cost per bed of the national average cost of construction for nursing home beds from the Square Foot Table, adjusting it for the Missouri cities indexes from the City Cost Indexes Table, and adding the per bed land cost determined by the division. This initial asset value will be adjusted annually using the estimated Historical Cost Indexes from the RS Means publication for each subsequent year. The resulting asset values are included in Appendix C.

(C) Average private pay rate. The usual and customary charge for non-Medicaid patients determined by dividing total non-Medicaid days of care into revenue collected from the same service that is included in the Medicaid per-diem rate, excluding negotiated payment methodologies with state or federal agencies, such as the Veterans Administration and the Missouri Department of Mental Health.

(D) Cost report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in subsection (10)(A) of this regulation and all worksheets supplied by the division for this purpose. The cost report shall detail the cost of rendering both covered and noncovered services for the fiscal reporting period in accordance with the procedures prescribed by the Division.

(E) Department. The Department, unless otherwise specified, refers to the Missouri Department of Social Services.

(F) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit.

(G) Director. The director, unless otherwise specified, refers to the Director, Missouri Department of Social Services.

(H) The Division of Aging. The division of the Department of Social Services responsible for survey, certification and licensure of LTC facilities.

(I) The Division of Medical Services. Unless otherwise designated, division as used in this regulation refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) program.

(J) Entity. Any natural person, corporation, not-for-profit corporation, professional corporation, business, partnership or something that exists as a particular and distinct unit.

(I) Interest and Borrowing Costs on Capital Asset Debt.

(1) Interest and borrowing costs related to necessary loans associated with capital asset debt are accounted for in the capital cost component and are subject to debt and interest rate restrictions. Determination of allowable interest and borrowing costs is detailed in parts (11)(A)3.B.(III) and (11)(A)3.B.(IV).

(2) Loans must be supported by evidence of a written agreement that funds were borrowed and repayment of the funds are required, identifiable in the provider's accounting records, related to the reporting period in which the costs are claimed, and necessary for the operation, maintenance or acquisition of the provider's facility.

(3) Necessary means that the loan be incurred to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

(4) A provider shall capitalize borrowing costs and amortize them over the life of the loan on a straight line basis. Borrowing costs include loan costs (i.e. lender's title and recording fees, appraisal fees, legal fees, escrow fees, and other closing costs), prepaid interest and discounts. Finder's fees are not allowed.

(J) Utilization Review. Costs incurred for the performance of required utilization review.

(K) Nursing Facility Reimbursement Allowance (NFRA). Effective for service dates on or after October 1, 1996, the fee assessed to nursing facilities in the State of Missouri for the privilege of doing business in the state will be an allowable cost.

(8) Nonallowable Costs. Cost not reasonably related to pediatric nursing care facility services shall not be included in a provider's costs. In accordance with this section, contractual allowances, courtesy discounts, charity allowances and similar adjustments or allowances are offsets to revenue and are not included in allowable costs. Nonallowable cost areas include, but are not limited to, the following:

(A) Amortization on intangible assets;

(B) Attorney fees related to litigation;

(C) Bad debts;

(D) Capital cost increases due solely to changes in ownership, management, control, operation or leasehold interest;

(E) Central office or pooled costs not reasonably attributed to the efficient and economical operation of the facility;

(F) Charitable contributions;

(G) Compensation paid to a relative or an owner through a related party to the extent it exceeds the limitations established under subsection (7)(A) of this regulation;

and with valid participation agreements in effect on June 30, 1989, and which satisfy all the qualifications necessary for participation in the pediatric nursing care program described in this rule, the per-diem rate for capital under this rule shall be the sum of lines one hundred and six (106), one hundred seven (107), one hundred eight (108) and one hundred ten (110) from the Financial and Statistical Report for Nursing Facilities portion of the applicable cost report, divided by the greater of patient days for the reporting period from line eight (8), item six (6), column (8) or ninety-three percent (93%) of the total bed days for the reporting period from line eight (8), item five (5), column eight (8). The capital cost per-diem rate shall be fixed and will not be adjusted except as may be authorized under section (12) or (13). If a facility replaces all beds with a new facility, the capital per diem rate will be determined by subparagraph (11)(A)3.B.

B. For new facilities, replacement beds/facility and additional beds, the per-diem rate for capital shall be

determine using the fair rental value system (FRV), which consists of four (4) elements; rental value, return, computed interest, and borrowing costs. The determination of the per-diem for each element is as follows:

(I) Rental value. The rental value is a computed figure determined as follows:

(a) Determine the total asset value.

I. Determine facility size from the rate setting cost report;

II. Determine the number of increased licensed beds through the end of the rate setting period;

III. Determine the bed equivalency for renovations/major improvements by taking the cost of the renovations major improvements divided by the asset value per bed for the year of the renovation/major improvement rounded to the nearest whole bed. For a rate setting cost report, the renovation/major improvement must be completed by the end of the rate setting period. The cost must be at least the asset value per bed for the year of the renovation/major improvement.

IV. Determine the number of decreased licensed beds through the end of the rate setting period;

V. Determine the total facility size which is the sum of items I., II., III. less IV; and

VI. Determine the total asset value which is the total facility size multiplied by the asset value relating to the rate setting cost report as set forth in subsection (4)(B).

"Substitute per letter dated 6/12/02"

(b) Determine the reduction for age by multiplying the age of the beds by one percent (1%).

I. The age of the beds for multiple licensing dates is calculated on a weighted average method rounded to the nearest whole year. For example, a facility with original licensure in 1979 of sixty (60) beds, an additional licensure of sixty (60) beds in 1984, and an additional licensure of ten (10) beds in 1998, with a rate setting cost report ending in 2000, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age times Beds
1979	21	60	1260
1984	16	60	960
1998	2	10	20
Total		130	2240

Weighted Average Age - - 2240 / 130 beds = 17.23 years rounded to 17 years.
This results in a reduction for age of the beds at 17%

II. The age of the beds for replacement beds is calculated on a weighted average method rounded to the nearest whole year as set forth in the Certificate of Need (CON). For example, a facility with one hundred twenty (120) beds licensed in 1978 with replacement of sixty (60) beds in 1998, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age times Beds
1978	22	60	1320
1998	2	60	120
Total		120	1440

Weighted Average Age - - 1440 / 120 beds = 12.00 years. This results in a reduction for age of the beds at 12%

III. The age of the beds for reductions in licensed beds is calculated on a weighted average method rounded to the nearest whole year as set forth in the CON. For example, a facility with original licensure in 1979 of sixty (60) beds, an additional licensure of sixty (60) beds in 1984, an additional licensure of ten (10) beds in 1998 and a reduction of ten (10) beds in 1989, the reduction percentage is calculated as follows:

Licensure Year	Age	Beds	Age times Beds
1979	21	60	1260
1984	16	60	960
1998	2	10	20
1989*	21	(10)	(210)
Total		120	2030

* reduction of 1979 beds

Weighted Average Age - - 2030 / 120 = 16.92 years rounded to sixteen (17) years.
This results in a reduction for age of the beds at 17%.

IV. The age of the bed equivalents for renovations/major improvements is

Substitute per letter dated 6/12/02

calculated on a weighted average method rounded to the nearest whole year. For example, a one hundred twenty (120) bed facility licensed in 1979 undertakes two (2) renovations: $200,000 in 1983 and $100,000 in 1993. The asset value per bed is $25,250 for 1983 and $32,039 for 1993. The bed equivalency is eight (8) beds for 1983 and three (3) beds for 1993; the reduction percentage is calculated as follows:

Licensure/ Construction Year	Age	Beds	Age times Beds
1979	21	120	2520
1983	17	8	136
1993	7	3	21
Total		131	2677

Weighted Average Age - - 2677 / 31 = 20.44 year rounded to twenty (20) years.
This results in a reduction for age of the beds at 20%

(c) Determine the facility asset value. The facility asset value is the total asset value per subpart (11)(A)3.B.(I)(a) less the reduction for age per subpart (11)(A)3.B.(II)(b).

(d) Determine the rental value. Multiply the facility asset value by two and one-half percent (2.5%) to determine the rental value. The two and one-half percent (2.5%) is based on a forty (40)-year life.

(e) The following is an illustration of how subparts (11)(A)3.B.(I)(a), (b), (c) and (d) determine the rental value.

I. Assumptions:

2000 Rate Setting Cost Report	
Licensed beds	120
Bed Equivalents	4
Weighted average age of the beds	23 years
Asset value - 2000	$34,797

II. The total asset value is the product of the total facility size times the asset value;

Total facility size	124
Asset value	x $ 34,797
Total asset value	$ 4,314,828

III. The facility asset value is the total asset value less the reduction for age of the beds;

Total asset value	$4,314,828
Reduction for age (23%)	$ 992,410
Facility asset value	$3,322,418

IV. The rental value is the facility asset value multiplied by 2.5%.

Facility asset value	$3,322,418
	X 2.5%
Rental value	$ 83,060

(II) Return. The return is a computed figure, subject to rate limitations, as set forth below:

(a) Reduce the facility asset value by the capital asset debt, but not less than zero (0), times the rate of return. The rate of return is the yield for the thirty (30)-year Treasury Bond as reported by the Federal Reserve Board and published in the Wall Street Journal at the end of the first week in September, plus two (2) percentage points.

Substitute per letter dated 6/12/02

(b) The debt associated with increases in licensed beds or renovations/major improvements for rate setting cost reports as set forth in items(11)(A)3.B.(I)(a)II. and III., will be added to the capital asset debt from the rate setting cost report. The facility shall provide adequate documentation to support the additional debt as required in subsection (7)(I). If adequate documentation is not provided to support the additional capital asset debt, it will be assumed to equal zero (0).

(c) The following is an illustration of how subpart (11)(A)3.B.(II)(a) is calculated continuing the example from above in (11)(A)3.B.(I) and assuming capital asset debt of $1,371,094:

Facility asset value	$ 3,322,418
Capital asset debt	($ 1,371,094)
	$ 1,951,324
Rate of Return	x 9.18%
Return	$ 179,132

(III) Computed interest. The interest is a computed figure, subject to capital debt and interest rate limitations, as set forth below:

(a) Interest will be calculated by multiplying the lessor of the necessary outstanding capital asset debt or the facility asset value as determined in subpart (11)(A)3.B.(I)(c) by the Chase Manhattan prime rate in effect on the first business day in September, as published in the Wall Street Journal, plus two (2) percentage points. The interest rate in effect at the end of the rate setting period shall be used.

(b) The following is an illustration of how interest is calculated:

Assumptions:

	Example A: Facility Asset Value < Debt	Example B: Facility Asset Value > Debt
Facility asset value	$3,322,418	$3,322,418
Outstanding capital asset debt	$3,500,000	$1,951,324
Term of debt	25 years	25 years
Prime rate - September 1, 1999	8.25%	8.25%

Interest calculation:
The lessor of the facility asset value or the outstanding capital asset debt multiplied by the allowable interest rate (prime rate + 2%)

	Ex. A	Ex. B
Facility asset value	$3,322,418	
Outstanding capital debt		$1,951,324
Interest rate	x 10.25%	x 10.25%
Computed interest	$ 340,548	$ 200,011

(IV) Borrowing costs.

(a) A provider shall capitalize borrowing costs and amortize them over the life of the loan on a straight line basis.

(b) If loans for capital asset debt exceed the facility asset value, the borrowing costs associated with the portion of the loan or loans which exceeds the facility asset value shall not be allowable.

(c) The following is an illustration of how allowable borrowing costs are calculated:

Assumptions:	
Loan costs	$120,000
Discount costs	$125,000
Borrowing costs	$245,000

	Ex. A	Ex. B
Facility asset value	$3,322,418	$3,322,418
Outstanding capital asset debt	/ $3,500,000	/ $1,951,324
Percent of borrowing costs allowed	95%	100%
Borrowing costs	x $ 245,000	x $ 245,000
Allowable portion to be amortized	$ 232,750	$ 245,000
Term of debt	/ 25 yrs	/ 25 yrs
Allowable borrowing costs	$ 9,310	$ 9,800

(V) Capital per diem calculation. Two (2) per diems are calculated using the above computed figures and summed to determine the total capital per diem rate, as set forth below.

(a) FRV per diem. A per diem is calculated by dividing the sum of the rental value, the return and the computed interest by the annualized patient days. Annualized patient days equals the total facility size determined in item(11)(A)3.B.(I)(a)V. times three hundred sixty-five (365) adjusted by the greater of ninety percent (90%) or the facility's occupancy from the rate setting cost report. The following is an illustration of how this calculated:

Rental Value	S 83,060
Return	$179,132
Computed interest (from Exhibit B)	$200,011
Total	$462,203
Divided by annualized patient days	/ 40,734*
FRV per diem	S 11.35

* Annualized patient days:

Total facility size	124
Times 365	x 365
Subtotal	45,260
Greater of minimum utilization or facility occupancy	x 90%**
Annualized patient days	40,734

** Assumption: facility occupancy from the rate setting cost report below 90%

(b) Borrowing costs per diem. A per diem is calculated by dividing the sum of the borrowing costs by the greater of ninety percent (90%) of the total bed days from the rate setting cost report or the facility's patient days from the rate setting cost report. The following is an illustration of how this is calculated:

Borrowing costs (from Ex. B)	$9,800
Patient Days	/ 39,420*
Borrowing cost/pass through per diem	$ .25

* Patient days - greater of:
– Ninety percent of bed days = 120 beds x 365 days x 90% = 39,420
– Facility patient days = 37,890 (Assumption)

(c) The capital per diem is the sum of subparts (11)(A)3.B.(V)(a) and (11)(A)3.B.(V)(b).

Substitute per ... 6/12/02"

FRV per diem	$11.35
Borrowing costs/pass through per deim	$ .25
Total capital	$11.60

The capital cost per-diem rate shall be fixed and will not be adjusted except as may be authorized under section (12) or (13).

(B) New Facilities.

2. A provider may request a rate adjustment for replacement beds/facility. The facility must obtain an approved certificate of need or applicable waiver for the replacement beds facility. The facility shall provide all documentation requested by the division relating to the replacement beds/facility.

A. The capital per diem is calculated for the replacement beds/facility as set forth in subparagraph (11)(A)3.B. using the asset value, rate of return, and interest rate in effect for the date the replacement beds/facility are placed in service. The rate adjustment will be calculated as the difference between the facility's capital per diem prior to the replacement beds/facility being placed in service and the capital per diem including the replacement beds/facility.

B. The rate adjustment will be incorporated into the facility's per diem rate by replacing its capital per diem prior to the replacement beds with the capital per diem including the replacement beds.

3. A provider may request a rate adjustment additional beds. The facility must obtain an approved certificate of need or applicable waiver for the additional beds. The facility shall provide all documentation requested by the division relating to the additional beds.

A. The capital per diem is calculated for the additional beds as set forth in subparagraph (11)(A)3.B. using the asset value, rate of return, and interest rate in effect for the date the additional beds are placed in service. The rate adjustment will be calculated as the difference between the facility's capital per diem prior to the additional beds being placed in service and the capital per diem including the additional beds.

B. The rate adjustment will be incorporated into the facility's per diem rate by replacing its capital per diem prior to the additional beds with the capital per diem including the additional beds.

Substitute per letter dated 6/12/02-n

4. The request for rate reconsideration must be submitted in writing to the Division, must specifically and clearly identify the reason for the request, must include sufficient documentation evidencing that the costs were actually incurred, must be in detail sufficient for the division to determine whether or not the costs were or were not included in the rate, and must include the amount requested;

5. The Division will make a recommendation to the director of the Department of Social Services within sixty (60) days following the receipt of all documentation required or necessary, or both, to evaluate the request. The director's or his / her designee's final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the Division's recommendation; and

6. The director's or his / her designee's final determination on the Division's recommendation shall become effective on the first day of the month in which the request was made providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective on the first day of the following month.

(13) Rate Adjustments.

(A) Unless specifically provided elsewhere in these rules, the division may increase or decrease the per-diem rate both prospectively and retrospectively only under the following conditions:

1. Pursuant to a court decision; or

2. Pursuant to an Administrative Hearing Commission decision or order.

APPENDIX C

Year	Asset Value
1994	S 32,330
1995	S 32,723
1996	S 32,921
1997	S 33,355
1998	S 33,829
1999	S 34,205
2000	S 34,797